Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA ROAD PASADENA EX 77504	MFDR Tracking #: M4-09-7249-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: AMERICAN HOME ASSURANCE COMPANY Rep Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Provider submitted an erroneously marked bill as a 'corrected claim' requesting 'Separate Reimbursement to Hospital for Implantables Requested,'…It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement. If calculated pursuant to sections 134.404(f)(1)(B) and (g), reimbursement should be **$18,179.32**…Carrier's payment of $14,492.21 is still less than the amount that Service cannot be review without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing. Vista should have been reimbursed if it had not requested that implantables be reimbursed separately under 134.404(f)(1)(B), specifically, $14,861.22. It is unclear what methodology Carrier used to calculate reimbursement, but it is clear that the amount reimbursed is insufficient under the Fee Guideline. Therefore, the Carrier is required to reimburse Provider **$18,179.43** pursuant to the Inpatient Fee Guideline…The Carrier made a partial payment of **$14,492.21.** Therefore, the Carrier is required to reimburse Provider in the amount of **$3,687.22**, plus any and all applicable interest."

Principal Documentation:

1. DWC 60 package
2. Hospital BillS
3. EOBs
4. Implant Invoices
5. Implant Billing Certification
6. Total Amount Sought $3,687.22

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Carrier allowance reconfirmed as correct on basis of submitted billing, documentation, DRG, & invoices received to date in accordance with TDI/DWC Rule 134.404. Correct reason/exception/explanation codes have been utilized. Extensive EOB's have been mailed to provider detailing payment calculation methodology & request for implant invoices. However, 1 implant remains unpaid, as no invoice submitted, even though clearly requested on 3 EOB's confirmed as received by provider (copies submitted with MDR request). Carrier respectfully makes 4th request for submission of purchase invoice for the following provider charge; additional reimbursement would be paid to provider, invoice cost + 10%: FRAME C-JAWS CERVICAL STAPLE charge $17,475."

Principal Documentation:

1. DWC 60 response

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
03/26/2008 through 03/27/2008	Inpatient Hospital Services	$11,541.58 (DRG 473) (IPPS) X 108% = $12,464.91 + $2,043.91 (Implantable Allowance) = $14,508.82 (MAR) less $14,492.21 (Total paid by Respondent) = $16.61 (Amount Due Requestor)	$3,687.22	$16.61
			Total Due:	$16.61

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 TAC §134.404, titled ***Hospital Facility Fee Guideline – Inpatient,*** effective for medical services provided in an inpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital inpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for medical dispute resolution under 28 TAC §133.305 (a)(4).

1. The disputed services were denied or reduced by the insurance carrier based upon:
   Explanation of benefits with the listed date of audit 05/21/2008
   - 11 — The recommended allowance for the supply was based on the attached invoice.
   - 13 — An additional allowance has been recommended for implants/prosthetics.
   - 16 — Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 97 — Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 — Worker's Compensation State Fee Schedule adjustment.
   - 169 — Reimbursement based on ratio, percentage or formula set by state guidelines.
   - 243 — The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 275 — The charge was disallowed as the submitted report does not substantiate the service being billed.
   - 285 — Please refer to the note above for a detailed explanation of the reduction.
   - 295 — Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
   - B12 — Services not documented in patients medical records.
   - 5036 — Complex bill - Reviewed by Medical Cost Analysis Team.

   Explanation of benefits with the listed date of audit 07/10/2008
   - 11 — The recommended allowance for the supply was based on the attached invoice.
   - 13 — An additional allowance has been recommended for implants/prosthetics.
   - 16 — Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 97 — Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 — Worker's Compensation State Fee Schedule adjustment.
   - W4 — No additional reimbursement allowed after review of appeal/reconsideration.
   - 169 — Reimbursement based on ratio, percentage or formula set by state guidelines.
   - 243 — The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 275 — The charge was disallowed as the submitted report does not substantiate the service being billed.
   - 285 — Please refer to the note above for a detailed explanation of the reduction.
   - 295 — Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
   - B12 — Services not documented in patients medical records.
   - 5036 — Complex bill - Reviewed by Medical Cost Analysis Team - UR/JE

   Explanation of benefits with the listed date of audit 02/26/2009
   - 11 — The recommended allowance for the supply was based on the attached invoice.
   - 13 — An additional allowance has been recommended for implants/prosthetics.
   - 16 — Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - W1 — Worker's Compensation State Fee Schedule adjustment.
   - W3 — Additional payment made on appeal/reconsideration.
   - 193 — Original payment decision is being maintained. This claim was processed properly the first time.
   - 295 — Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
   - 1001 — Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 5036 — Complex bill – reviewed by Medical Cost Analysis Team – UR/JE.
   - 5101 — Please refer to note above for a detailed explanation of the additional information needed to process your billing.

2. Division rule at 28 TAC §134.404(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. The respondent denied reimbursement for implantable C-Jaws based on denial reason code 295, lack of invoice. Review of documentation finds no invoice to support the disputed service. This denial reason is supported. Therefore, reimbursement for the C-Jaws is not recommended.
4. Pursuant to Division rule at 28 TAC §134.404(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be Multiplied by 108 percent."
5. Pursuant to Rule §134.404(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1))B) of this section, shall be reimbursed at the lesser of the manufacturers invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, which ever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge'."
6. The requestor asserts in the position summary letter dated 03/24/2009 that "Provider submitted an erroneously marked bill as a 'corrected claim' requesting 'Separate Reimbursement to Hospital for Implantables Requested,' the bill submitted contain the same procedure code, same charges, with calculation are the same as the bill initially. We are requesting separate reimbursement for implants. On February 02, 2008, provider once again sent Carrier a Request for Reconsideration noting that Carrier failed to reimburse Provider pursuant to the appropriate sections of the fee guideline applicable when Provider requests separate reimbursement for implantables, specifically, 28 TEX. ADMIN. section 134.404(f)(1)." Review of the initial and reconsideration medical bills submitted by the requestor finds that "SEPARATE REIMBURSEMENT TO HOSPITAL FOR IMPLANTABLES REQUESTED" is clearly stamped on both initial and reconsideration bills submitted to respondent. No documentation was found to support that the requestor ever communicated to the carrier, prior to the request for medical fee dispute resolution, that an erroneous billing had been submitted. No documentation was submitted to support that the requestor ever timely submitted a corrected claim to the insurance carrier in accordance with Division rule at 28 TAC §133.20(b). No documentation was submitted to support that the provider requested reconsideration based on erroneous billing in accordance with Division rule at 28 TAC §133.250(d)(4). The requestor has not submitted documentation to support its position that separate reimbursement for implantables was not requested. The Division concludes that the provider requested separate reimbursement for implantables.
7. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables *WAS* requested by the requestor with the billing.

8. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.404(f)(1)(B) as follows:

Total Implantables Billed	Net Invoice Amount Per Implantable	Implant Description	Lesser of 10% or $1,000 per Billed Item Add-On §134.404(g)	Total Net Implantable Amount + Total Add-On (not to exceed $2,000 total add-on's per admission)
$955.00	$206.10	Paste DBM	$115.10	$1,270.00
$735.00 (X 3)	$400.00 (10/Box) divided by 10 = $40.00 each x 3 = $120.00	Screw Distraction	$120.00	$1,320.00
$6,128.00	$1,532.00	Fortitude Vue Convex	$153.20	$1,685.20
$17,475.00	Invoice Submitted does not match bill	Frame C-Jaws – Invoice Submitted does not match bill	$0.00	$0.00
$25,293.00	**$1,858.10**		**$185.81**	**$2,043.91**

The Medicare Facility Specific Reimbursement Amount including Outlier Payment Amount for DRG 473 is $11,541.58. $11,541.58 multiplied by 108% = $12,464.91.

The net invoice amount for implantables is $1,858.10 + $185.81 total add-on = $2,043.91.

$12,464.91 + $2,043.91 = $15,508.82 (MAR) less $14,494.21 previously paid by carrier = $16.61 due to requestor.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $16.61.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031, §413.0311
28 TAC Rule §134.404, §133.305, §133.307

PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provision of Texas Labor Code §413.031 and §413.019, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of **$16.61** plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	04/20/2010 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.